

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07781

07786

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR		
John		Samuel		Alburtis				June 20, 1968		12	35	P	M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Male	White	April 9, 1902		66 YRS		MONTHS		DAYS		June 20, 1968		19	12	35	P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Maryland		USA				Allegany									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Cumberland		Memorial Hospital		Rubber worker		Kelly									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Allegany		Cumberland				114 Polk Street							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Otha		Alburtis						Emma		Cooper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT											
No		705-07-9672		Mrs. Wilda Alburtis		Cumberland, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Fractured Pelvis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 10			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9035															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year JUNE 18, 10:20 PM 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FELL OFF CURB OF STREET							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HANOVER STREET # 105				21f. LOCATION Street or R.F.D. No. City or Town County State HANOVER STREET CUMBERLAND ALLEGANY MD.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				June 20, 1968							
				ADDRESS (Street, city, town, or county) Cumberland, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6-23-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland							
24. FUNERAL DIRECTOR H. Lee Silcox				ADDRESS 404 Decatur St., Cumb., Md.				25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

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07782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Blanche		Middle		Last Ashby		2a. DATE KNOWN OF DEATH ESTI- MATED		Month June		Day 7		Year 1968		2b. HOUR 11:20 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 28, 1908		6. AGE (in years) last birthday 60 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		MIN. 0		2c. DATE PRONOUNCED DEAD Month June		Day 7	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Allegany											
10. CITY OR TOWN OF DEATH Barton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Barton, Md.					
14. FATHER'S NAME First Edwin				Middle		Last Taylor		15. MOTHER'S MAIDEN NAME First Sadie				Middle		Last Fairgrieve			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT James Ashby				ADDRESS Barton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 666 DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED June 8, 1968					
EXAMINER'S NAME (Type) Benedict Skitarelic						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ADDRESS (Street, city, town, or county) Cumberland, Md.																	
23a. BURIAL, CREMATION, or other (Specify) Burial				23b. DATE June 11, 1968				23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.				23d. LOCATION (City or Town) (County) (State) Moscow Mills Allegany Md.					
24. FUNERAL DIRECTOR E. J. Breal						ADDRESS Westernport, Md.						25. REC'D BY REGISTRAR DATE JUN 11 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 1-68
30M REV. 1-68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last GEORGE WILLIAM BEAL			2a. DATE OF DEATH JUNE Month 11 Day 1968		2b. HOUR 2:30A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 18, 1897		6. AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 634 ELM STREET CUMBERLAND			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED RAILROAD ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 634 ELM STREET CUMBERLAND MD.	
14. FATHER'S NAME First Middle Last GEORGE BEAL			15. MOTHER'S MAIDEN NAME First Middle Last AGNES OHLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) YES		(If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 705-10-7065		17. INFORMANT Address MRS MERLE KATHERINE BEAL 634 ELM ST CUMBERLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>6-mph pneumonia (Severe)</u> 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asthma -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor Pulmonale</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 6 mon									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 241X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>June 14</u> , 19 <u>68</u> ; that (I) (we) lost saw the deceased alive on <u>June 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clay E. Durrett</u>				22c. DATE SIGNED 6/14/68		22d. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 17 JUNE 68		23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) LAVALE ALLEGANY MARYLAND			
24. FUNERAL DIRECTOR ADDRESS H. LEE SILCOX 404 DECATUR STREET CUMBERLAND				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>			

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UNIT KILL OF DEATH

03388

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07784		07789								
1. DECEASED-NAME (Type or print)		First CATHY	Middle MARIE	Last BEALS	2a. DATE OF DEATH Month 6 Day 14 Year 68		2b. HOUR 9:15 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-13-68		6. AGE (In years last birthday) YRS. 1 MONTHS 1 DAYS 6 MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLE GANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE HYNDMAN		13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. 1, BOX 42-A		
14. FATHER'S NAME First WILLIAM Middle E Last BEALS		15. MOTHER'S MAIDEN NAME First ALICE Middle A Last TROUTMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7599 IMMEDIATE CAUSE (a) Congenital malformation DUE TO, OR AS A CONSEQUENCE OF Respiratory complications (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7593										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W R Hodges		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) DR. R. HODGES						
22e. ADDRESS CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Palo Alto Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Pa. RD#1				
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE JUN 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

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07782

DATE: 8-13-66 TIME: 11:00 AM

FROM: [illegible] TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 8-13-66

TIME: 11:00 AM

FROM: [illegible] TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 8-13-66

TIME: 11:00 AM

FROM: [illegible] TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 8-13-66

TIME: 11:00 AM

FROM: [illegible] TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

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VR A13-1
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) GEORGE				Middle Jackson		Last BILLMEYER		2a. DATE OF DEATH JUNE Month 24 Day 1968 Year		2b. HOUR A 11:45 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-4-13		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART		12a. USUAL OCCUPATION (Kind of work done during last working life, or if retired.) OWNED BUSINESS		12b. KIND OF BUSINESS OR INDUSTRY LIQUOR STORE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLBANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 756 GREENE ST.			
14. FATHER'S NAME First GEORGE Middle BILLMEYER Last BENNETT				15. MOTHER'S MAIDEN NAME First JULIA Middle BENNETT Last BENNETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-07-5229		17. INFORMANT HOSPITAL RECORD				Address SACRED HEART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1621 (b) Bronchogenic Carcinoma, Extensive DUE TO, OR AS A CONSEQUENCE OF (c) 8 mos. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bleeding Duodenal Ulcer + Serpiginous Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6/22 , 19 67 , to 6/24 , 19 68 , that (I) (we) lost saw the deceased alive on 6/24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. A. Pagan				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/25/68					
22d. PHYSICIAN'S NAME (Type) J. A. PAGAN, M.D.				22e. ADDRESS 5 POTOMAC ST., RIDGELEY, W. VA.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/27/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland (County) Alleghany (State) Md.					
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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GEORGE JACKSON JULY 21 1958

WHITE 7-1-12

U.S.A. 11521

21-1-12 11521

ALFRED J. BERNARD

GEORGE JACKSON JULY 21 1958

21-1-12 11521

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate should be removed from the pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
3004 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		P.M. HOUR	
BABY GIRL BLIZZARD						JUNE 18, 1968		11:20	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		JUNE 18, 1968		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		None		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
W.Va. MD.		Minera		Wiley Ford					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
WILLIAM BLIZZARD			MARY L. LAYTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no						MEMORIAL HOSPITAL, CUMB. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>fracture - 11/5/87</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
776X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>68</u> , to <u>6/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DR. W. ROYCE HODGES			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 20, 1968		St. Mary's Cemetery		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.					JUL 17 1968				

MEDICAL CERTIFICATION

134

81-13930

03780

03781

BABY

GIRL

BLISSARD

JUNE

18, 1966

FEMALE

WHITE

JUNE 16, 1968

MARRIED U.S.A.

ALLEGANY

COMERLAND

MEMORIAL HOSPITAL

WILLIAM

BLISSARD

MARY

L.

LAYTON

MEMORIAL HOSPITAL, COMERLAND, MD.

DR. W. ROYCE HODGES

COMERLAND, MD.

JUNE 17, 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
GRANVILLE BLOCHER						MAY 9, 1968		2:40 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
MALE	WHITE	MAY 28, 1920	48 YRS.	MONTHS	DAYS	HOURS	MIN.	JUNE 9, 1968	2:40 P	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
MARYLAND		U.S.A.				ALLEGANY		19 2:40 P		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG			MINERS HOSPITAL			TREAD ROOM - KS TIRE COMPANY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17 HIGH STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WILLIAM BLOCHER			HARRIETT HARDEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES			WW 2 217-09-8680		MRS. IDELMA H. BLOCHER, FROSTBURG, MD. 21532					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary Embolism =										
DUE TO, OR AS A CONSEQUENCE OF										
5621 Peritonitis 6 days										
(b) DUE TO, OR AS A CONSEQUENCE OF										
Ruptured Diverticulum of sigmoid 6 days										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5721										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JUNE 9, 1968		
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		JUNE 12, 1968		FBG. MEMORIAL PARK		FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
JOSEPH R. DURST, FROSTBURG, MD. 21532				JUN 12 1968		J. Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) WILLIAM E. BOWSER						2a. DATE OF DEATH 6 Month 15 Day 68 Year			2b. HOUR 3:15 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 31, 1895			6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.) RAILROAD			12b. KIND OF BUSINESS OR INDUSTRY RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.			13b. COUNTY Somerset		13c. CITY OR TOWN MEYERSDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD. 2, BOX 180		
14. FATHER'S NAME First CHARLES. Middle M. Last BOWSER				15. MOTHER'S MAIDEN NAME First DELIAH Middle MOSHOLDER Last BOWSER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 705 07 9408		17. INFORMANT HOSPITAL RECORD			Address 800 SETON DRIVE CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 68 , to 6-15 , 19 68 , that (I) (we) last saw the deceased alive on 6-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael L. Blick DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 6-18-68					
22d. PHYSICIAN'S NAME (Type) DR. MICHAEL L. BLICK						22e. ADDRESS 126 N. SMALL WOOD STREET CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-18-68		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery Meyersdale Somerset		23d. LOCATION (City or Town) (County) (State) MEYERSDALE ALLEGANY MD					
24. FUNERAL DIRECTOR H. R. Konrows ADDRESS Meyersdale, Pa.						25a. REC'D BY REGISTRAR JUN 20 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

07508

07508

WILLIAM F. BOGGER 6 12 6 1:12

NOTE UNIT MAY 31, 1962 75

U.S.A. ONLY

CUMBERLAND SACRED HEART HOSPITAL

CHRYSLER 1962 DEC 10

CHARLES H. BOGGER

205 07 01 SACRED HEART HOSPITAL

CUMBERLAND, MD

100 N. CHATEL WOOD STREET

CUMBERLAND, MARYLAND 21502

DR. MICHAEL L. GLICK

100 N. CHATEL WOOD STREET

CUMBERLAND, MARYLAND 21502

100 N. CHATEL WOOD STREET

CUMBERLAND, MARYLAND 21502

100 N. CHATEL WOOD STREET

CUMBERLAND, MARYLAND 21502

100 N. CHATEL WOOD STREET

CUMBERLAND, MARYLAND 21502

100 N. CHATEL WOOD STREET

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07789

07793

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED				2b. HOUR	
Edith Jo Anna Burgess						6-17 1968				8:45 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	July 23, 1893	74 YRS.					Month 6 Day 17 Year 1968		8:45 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Cross, W. Va.		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		119 E. Elder St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Jacob Evans			Jennie Swires								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no					Mrs. Madona Benson, Cumberland, Md. Daughter						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS -----	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			June 17, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			June 20, 1968		Sunset Memorial Park			Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						DATE JUN 25 1968			<u>Charles Judge</u>		

03770

RECEIVED - DEPARTMENT OF JUSTICE

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Leslie Preston Carnell						Month Day Year			1:10 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	Sept. 5, 1888	79 YRS.	MONTHS	DAYS	HOURS	MIN	Month 6 Day 17 Year 1968	1:10 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
W. Va.		USA				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			D.O.A. Memorial H.			Cabinet Maker			Lumber
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.			Allegany			Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	102 Seymour St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph Carnell			Eliza Bailey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
no						Mrs. Delta Carnell, Cumberland, Md. - Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									SUDDEN
IMMEDIATE CAUSE (a) 4109									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarelic						JUNE 17, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
Dr. Benedict Skitarelic, M.D.						Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		6-20-1968		Arnold Cemetery		Near Romney, W. Va.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				JUN 25 1968		Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Charles Hugh Cave						MATED <input checked="" type="checkbox"/> June 28-68		1 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	10/11/1916	51 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.		USA.				Allegany		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Westernport			Welsh Apts. Wash. St.			Wva. Pulp & Paper Co.		Paper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Allegany			Lonaconing			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Andrew Cave			Mabel Elizabeth Viands						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Yes War #2			217-05-0591			Gertrude Ann Darnley, Lonaconing, Md. (WIFE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial Infarction, Left									Days
DUE TO, OR AS A CONSEQUENCE OF									
(b) Coronary Occlusion									"
DUE TO, OR AS A CONSEQUENCE OF									
(c) Coronary Thrombosis									"
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				6/28/1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial				7/1/1968		Memorial Park		Frostburg, Md.	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR	
George Eichhorn						Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE	
						JUL - 1 1968		<i>J. Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First FRANCES		Middle M.		Last CENTOFONTI		2a. DATE OF DEATH Month Day Year JUNE 1 1968		2b. HOUR 8:15 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1-26-16/15		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) NEWCASTLE, PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done during preceding life, even if retired.) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 AVENUE M. POTOMAC PARK			
14. FATHER'S NAME First Middle Last PETER CENTOFONTI		15. MOTHER'S MAIDEN NAME First Middle Last ANNA PORZELLA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> (If yes give war or dates of service) No, <input checked="" type="checkbox"/> (unknown)		16b. SOCIAL SECURITY NO. 214-07-3783		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) coronary insufficiency - severe DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis & hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Diabetes chronic										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 days 15 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1958 , to 6/1 , 1968, that (I) (we) last saw the deceased alive on 5/29 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. G. WEISMAN		22c. DATE SIGNED 6/4/68		22d. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		22e. ADDRESS 59 GREENE ST., CUMBERLAND MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 5, 1968		23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.		23d. LOCATION (City or Town) (County) (State) CUMBERLAND MD					
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE JUN 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M-3. Page 5 may be retained for your files.

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07793

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07797

Item #5, Film #401 6 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Michael David Combs			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 8 Year 1968			2b. HOUR 8:00
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 15, 1954	6. AGE (In years last birthday) 13 YRS	IF UNDER 1 YEAR MONTHS 13 DAYS 13	IF UNDER 24 HRS. HOURS 13 MIN 30	2c. DATE PRONOUNCED DEAD Month June Day 9 Year 1968
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RFD #2-Hazen Road	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME First Addison Middle G Last Combs			15. MOTHER'S MAIDEN NAME First Evelyn Middle Howard Last Howard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Addison G. Combs		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 953 x ASPHYXIAATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) STRANGULATION DUE TO, OR AS A CONSEQUENCE OF (c) (HANGING-SELF INDUCED)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 974 x						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 9, 1968	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/11/68		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox				25a. REC'D BY REGISTRAR JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR INFO
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June 2, 1968

June 2, 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Kathleen			Cooper		Cooper		Cooper		Month Day Year	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
F			Colored		Feb 19 1907		61 YRS.		4 30 M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 1 YEAR	
Cumberland Md.			America				Allegheny County		MONTHS DAYS HOURS MIN	
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		13a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		14. KIND OF BUSINESS OR INDUSTRY		15. IF UNDER 24 HRS.	
Cumberland Md.			St. Joseph's Hospital		Teacher		Teacher		MONTHS DAYS HOURS MIN	
16a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			17b. CITY OR TOWN		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET AND NUMBER		20. IF UNDER 24 HRS.	
Cumberland Md.			Allegheny County		YES		306 Washington St.		MONTHS DAYS HOURS MIN	
21. FATHER'S NAME			22. MOTHER'S MAIDEN NAME		23. SOCIAL SECURITY NO.		24. INFORMANT		25. ADDRESS	
William			Elsie Benson		Cooper		Elsie Benson		Cooper	
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			27. SOCIAL SECURITY NO.		28. INFORMANT		29. ADDRESS		30. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			No		Elsie Benson		Cooper		6 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) cancer of the descending colon										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
metastatic carcinoma of the liver										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-25, 1968, to 6-9, 1968, that (I) (we) last saw the deceased alive on 6-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS	
Lewis Brings			6-9-68			Dr. Lewis Brings			Greene St. Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			6/12/68			Woodlawn Cem.			Cumberland Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Louis Stein Inc. - Cumb. Md.						JUN 12 1968			Charles Judge	

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UNITED STATES DEPARTMENT OF AGRICULTURE



UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.
OFFICE OF THE SECRETARY
DIVISION OF ENTOMOLOGY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First ELMER			Middle R		Last CORLEY		2a. DATE OF DEATH Month 6 Day 12 Year 68		2b. HOUR 9:30AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 3-26-91			6. AGE (In years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS OAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENN.			13b. COUNTY Bedford			13c. CITY OR TOWN HYNDMAN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME First CHARLES			Middle CORLEY			Last CLARA			15. MOTHER'S MAIDEN NAME First CLARA			Middle BARKLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 705-09-3608			17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 hrs														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>6-12, 1968</u> , to <u>6-12, 1968</u> , that (I) (we) last saw the deceased alive on <u>6-12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>V. P. Dross</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS						22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 15, 1968			23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery			23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.						25a. REC'D BY REGISTRAR DATE JUN 20 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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1-28-47

COMBERLAND, W.

DR. V. BRASS

COMBERLAND, W.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

07797

07801

1. DECEASED-NAME (Type or print)		First GUY		Middle W.		Last CRITES		2a. DATE OF DEATH		Month JUNE		Day 4		Year 1968		P. 2b. HOUR 10:30M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-5-1900		6. AGE (In years last birthday) 67		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.			
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.											
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Crane operator		12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ROUTE 6									
14. FATHER'S NAME First WILLIAM		Middle CRITES		Last CRITES		15. MOTHER'S MAIDEN NAME First MARY		Middle Elizabeth		Last SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 232-10-5633		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Valvular heart disease (AS and MI)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>5-23, 1968</u> , to <u>6-4, 1968</u> , that (I) (we) lost saw the deceased alive on <u>6-4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Charles P. Dross MD</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-4-68											
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS		22e. ADDRESS CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.											
24. FUNERAL DIRECTOR Philip B. Wendt		ADDRESS 121 Memorial Ave. Cumb. Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07798									
07802									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR P
William			T. Damm			Month Day Year			3:25 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		7-14-1892		75 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U. S.				Allegany Co. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland, Md.		Cumberland Nursing Center-German Brewery		Brewery					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Allegany		Cumberland				217 Bedford St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Otto Damm			Agnes Cole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-05-6727		Ruth Gray		110 Gleason St., Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								7 mo.	
IMMEDIATE CAUSE (a) Myocardial Failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic Heart Disease								1 yr.	
DUE TO, OR AS A CONSEQUENCE OF									
(c) Diabetes mellitus								16 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
Cerebral arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none		none		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year		none					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		none		Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1967, to June 13, 1968, that (I) (we) last saw the deceased alive on June 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 3.25 PM									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
James P. Hallinan M.D.								6-13-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
James P. Hallinan M. D.				140 Bedford St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/16/68		Zion Memorial Park		Cumberland Alleg Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Lee Silcox				Cumberland, Maryland 21502		DATE JUN 17 1968		James P. Hallinan	

APR 15 1968

U.S. DEPARTMENT OF AGRICULTURE

James I. Wellman, Jr., 1000 Lefford St., Washington, D.C.

none

none

none

none

James I. Wellman, Jr.

1000 Lefford St.

Washington, D.C.

James I. Wellman, Jr.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07803

1. DECEASED-NAME (Type or Print)			First Michael			Middle Leroy			Last Dixon			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year			2b. HOUR 9:45 ^a M					
3. SEX Male			4. RACE White			5. DATE OF BIRTH March 2, 1968			6. AGE (In years lost birthday) YRS. 3 MONTHS 16 DAYS			IF UNDER 1 YEAR HOURS MIN.			2c. DATE PRONOUNCED DEAD Month JUNE Day 18 Year 1968			2d. HOUR 9:45 ^a M		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany						Md.					
10. CITY OR TOWN OF DEATH Cumberland,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Sacred Heart			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None, infant			12b. KIND OF BUSINESS OR INDUSTRY None											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Rawlings,			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Along U. S. Rt. # 220								
14. FATHER'S NAME First Melvin Middle L. Last Dixon			15. MOTHER'S MAIDEN NAME First Theresa Middle -- Last Grogg																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None			17. INFORMANT Mr. Melvin L. Dixon, Rawlings, Maryland			ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X LOBAR PNEUMONIA, BILATERAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2-3 DAYS DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 490x																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE Benedict Skitarelic			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED JUNE 18, 1968											
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/21/68			23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery			23d. LOCATION (City or Town) (County) (State) Dawson, Allegany Md.											
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE JUN 21 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages must be removed from the certificate and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07800		MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07804	
1. DECEASED-NAME (Type or print)		First PALMER	Middle RAY	Last EMERICK	2a. DATE OF DEATH Month Day Year JUNE 27, 1968		2b. HOUR 3:25
3. SEX MALE	4. RACE WHITE		5. DATE OF BIRTH 12-25-17		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) CARMAN		12b. KIND OF BUSINESS OR INDUSTRY W. MD. RWY.	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last ROSS T. EMERICK		15. MOTHER'S MAIDEN NAME First Middle Last MARY CATHERINE YOHN		13e. STREET AND NUMBER Brant Road, Box # 81			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, W.W.#2		16b. SOCIAL SECURITY NO. 214-07-4015		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction, inferior APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 Jan 68 4109 DUE TO, OR AS A CONSEQUENCE OF acute myocardial infarction 3 Dec 65 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 DUE TO, OR AS A CONSEQUENCE OF acute myocardial infarction, anteroseptal 10 May 65 (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Cerebral thrombosis with incomplete L. hemiplegia Jan. 66 acute mellitus. mild 3 years.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10 May, 1968 , to 27 June, 1968 , that (I) (we) last saw the deceased alive on 26 June 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Alfred Van Ormer				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 28 June 68	
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposition (City) Burial		23b. DATE 6/29/68		23c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery		23d. LOCATION (City or Town) (County) (State) nr. Rawlings, Allegany Md.	
24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE JUL - 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03860

1988

BALMER RAY M. EMBERT JUNE 27, 1988

WEE WHITE 12-2-17

PEAN. U.S.A. ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL CARMAN

MD. ALLEGANY OPERATIONS X BONE JOINT, Dec 4-11

ROSS T. EMBERT MARK CATHERINE JOHN

MD. 814-01-4012 MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. N. A. VAN ORDER CUMBERLAND, MD.

MD. ALLEGANY ALLEGANY

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 100 (4)
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07801									
CERTIFICATE OF DEATH									
07805									
1. DECEASED-NAME (Type or print) First Middle Lost WILLIAM ADAM FABRI					2a. DATE OF DEATH Month 19 Day 1968 Year		2b. HOUR 6:30 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 12, 1907		6. AGE (In years lost birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D O A MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ELEVATOR OPERATOR - KS TIRE CO.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Lost LUCINDO FABRI					15. MOTHER'S MAIDEN NAME First Middle Lost BENILDA CASTELLANI				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 214-05-9781		17. INFORMANT Address BOX 123, MRS. KATHRYN FABRI, CRESAPTOWN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Crown Thrombosis DUE TO, OR AS A CONSEQUENCE OF, (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 12 hr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 341/58 Cypress Alley					
22a. I certify that (I) (this hospital) attended the deceased from 6/15/68 , 19 68 , to 6/21/68 , 19 68 , that (I) (we) saw the deceased alive on 6/15/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard J. Williams DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/21/68		
22d. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS, M. D.					22e. ADDRESS 122 CENTER ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-22-68		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. 21532					25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

2015/02/21

X *[Signature]*

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07802

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07806

1. DECEASED-NAME (Type or print) ALBERT NMI FISHER			2a. DATE OF DEATH Month JUNE Day 5 Year 68			2b. HOUR 7:45 AM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-9-03		6. AGE (In years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 237 WELSH HILL		
14. FATHER'S NAME First WILLIAM Middle C Last FISHER			15. MOTHER'S MAIDEN NAME First MARY Middle E. Last PLUMMER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-01-3601		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with left hemiplegia, status 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 yrs 68 3+ years. ?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 28 apr. 1968 , to 3 june 1968 , that (I) (we) last saw the deceased alive on 4 june 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. A. Van Ormer, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3 june 68			
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER						22e. ADDRESS XENOPOL CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/7/1968		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg Alleg Md					
24. FUNERAL DIRECTOR John J. Hafer Jr.						24a. ADDRESS Jr. 230 Balto Ave. Cumberland Md		24b. REC'D BY REGISTRAR DATE JUN 10 1968		24c. REGISTRAR'S SIGNATURE Charles Judge	

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ALBERT J. FISHER 1902 1902 1902

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MALE

UNITED STATES

DEPARTMENT

MEMORIAL HOSPITAL

DEPARTMENT

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MEMORIAL HOSPITAL, DUBLIN, IRE.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07803									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Benjamin			William Flack			June 19			1968 11:30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Aug. 1, 1895		72 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Md.		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Memorial Hospital			Retired Gov. Emp.			Adm. VA
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Allegany Cumberland					435 Williams St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
David B. Flack			Cornelia Masson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
yes			War I			213-10-3626 Mrs. Francies Flack, Cumberland, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>5 yr</u> <u>2 yr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>68</u> , to <u>June 19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clay E. Durrett</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 21, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.						22e. ADDRESS 236 Virginia Ave., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 21, 1968		Greenmount Cemetery		Baltimore, Baltimore, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE JUN 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10070

10070

UNITED STATES OF AMERICA



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07804											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ARTHUR			Middle HARMAN			Last FLURSHUTZ		
2a. DATE OF DEATH			Month JUNE			Day 30			Year 1968		
2b. HOUR			2:27			MIN.			PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-20-08		6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	
7a. BIRTHPLACE (State or foreign country) CUMB. MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Upholsterer		12b. KIND OF BUSINESS OR INDUSTRY Furniture Bus.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 856 GEPHART DRIVE			
14. FATHER'S NAME First FREDERICK		Middle FLURSHUTZ		15. MOTHER'S MAIDEN NAME First LAURA		Middle C		Last RESLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		(If yes give war or dates of service) W. W. #11		16b. SOCIAL SECURITY NO. 214-05-6225		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Appendiceal Abscess</u> 5400 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5501</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>See Advanced Multiple Sclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (a) (this hospital) attended the deceased from <u>22 June, 1968</u> , to <u>30 June, 1968</u> , that (b) (we) last saw the deceased alive on <u>29 June, 1968</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Med. W. Miltenberger, M.D.</u>				22c. DATE SIGNED <u>2 July 68</u>				22d. PHYSICIAN'S NAME (Type) DR. F. W. MILTENBERGER			
22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 7/3/68		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION (City or Town) Cu-berland, Allegany, Md.		(County)		(State)	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUL - 5 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1415 (4)
30M REV. 1/68

07805

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07809

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
GEORGE M. FURSTENBERG						6 Month 18 Day 68 Year			5:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	
MALE		WHITE		8-18-1887 AUG. 18, 1887		80 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		RAILROAD Boilermaker		RAILROAD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				115 FIFTH STREET			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
WILLIAM					FURSTENBERG	FLORENCE KELLER FURSTENBERG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <u>NO</u> (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			900 SETON DRIVE CUMBERLAND, MARYLAND			
			705-09-9800		SACRED HEART HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tobacco Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and Bronchiectasis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unk.</u> <u>unk.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>526x</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/8/68</u> , 19 <u>68</u> , to <u>6/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/19/68</u>			
22d. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN				22e. ADDRESS 5 POTOMAC STREET RIDGELEY, WEST VIRGINIA							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		June 21, 1968		Hillcrest Burial Park				Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR SCARPELLI'S FUNERAL HOME				ADDRESS James F. Scarpelli		25a. REC'D BY REGISTRAR DATE JUN 25 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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WEST VIRGINIA UNIVERSITY

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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07806

CERTIFICATE OF DEATH

07810

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR					
Novella				Gray	6th. 13th. 1968		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
Female		White		4/30/1886		82 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.				
MD.		USA.				Allegany						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Lonaconing			Kyle Nurseing Home			None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			Allegany			Cumberland		YES		218 Columbia St.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
Frank				Pearce	Susan Michaels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No					Dorothy Robertson Frostburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Ischemia</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4301</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1968</u> , to <u>June 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
<u>L.R. Miles, Jr. M.D.</u>		<u>6-13-68</u>			<u>L.R. MILES, JR. M.D.</u>		<u>Lonaconing Md</u>		<u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		6/15/1968		Laurel Hill Cemetery		Moscow, Md.						
24. FUNERAL DIRECTOR		George Eichhorn		Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Alex			Z.	Green	June 2 1968		2:35AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male		white		July 12, 1900		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Poland		U.S.A.				Allegheny			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		10 Johnson St.		Furrier		Processing furs			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegheny		Cumberland				10 Johnson St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Samuel				Green	Rachel				Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				William Green		6506 Kenhove Dr. Bethesda Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute Left Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Coronary Arteriosclerosis, Myocardial Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed. Over 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Mitral Insufficiency, old rheumatic									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/19/67, 19, to 6/21, 1968, that (I) (we) last saw the deceased alive on 5/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 3, 1968
22d. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M. D.					22e. ADDRESS 50 Pershing St., Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 3, 1968		King David Mem. Park		Falls Church Virginia			
24. FUNERAL DIRECTOR Goldberg Funeral Home Washington, D.C.					25a. REC'D BY REGISTRAR DATE JUN 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 5, Film G401 6/14/68 km										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
CHARLES			S. GRIFFEY			JUNE 6		1968		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		OCTOBER 4, 1890		77				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSP.			CARPENTER-WELDER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		127 POLK ST.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
CHARLES			GRIFFEY			EMMA GRIFFEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES			WW 1		206 05 5122		QUENTIN GRIFFEY ELLERSLIE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4201</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Sclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Emphysema, severe-Bronchitis, chronic, Arteriosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				None						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1964</u> , to <u>June 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. <u>6:40 AM</u>										
22b. SIGNATURE <u>James P. Hallinan M.D.</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-7-68</u>	
22d. PHYSICIAN'S NAME (Type) JAMES P. HALLINAN, M.D.					22e. ADDRESS 140 BEDFORD ST., CUMBERLAND MD. 2150					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		6/8/68		PORTER CEMETERY		RT. 1 HYNDMAN, PA.				
24. FUNERAL DIRECTOR BYRON KIGHT					ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE <u>Jun 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

30252

DATE	TIME	LOCATION	REMARKS
10/1/77	10:00	10000	10000

NOVEMBER 1954

Y333150	AMHE	NAME: JOC	Y333150	2316080
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07809				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07813							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
George				Harmon		Hansford		Month June Day 22 Year 68				6:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		1/12/1875				93 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
West Virginia		U.S.		WIDOWED		DIVORCED		Allegany County Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland				Allegany County Institution				Railroad worker				W. Md. Rwy.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
W. Va.				Mineral		Ridgeley		YES NO		Rt. 1 Carpenters Add.					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME					
David				W.		Hansford		Icie		M. Ball					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT									
No				705-10-8416		Allegany County Infirmary-Furnace St. ext. 4									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chr. ASH De Portis Stenosis</u> 4201 <u>Chr. Myocardial Infarction - Subtotal L. and R. -</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>approx. 3 hrs.</u> <u>many years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES NO							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> , 19 <u>68</u> , to <u>June 22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John A. Tepper M.D.</u>												22c. DATE SIGNED <u>June 25 - 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>John A. Tepper M.D.</u>												22e. ADDRESS <u>Memorial Hospital Cumberland, Md.</u>			
23a. BURIAL, CREMATION, BURNING (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				6/25/68		Zion Memorial Park				Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Maryland</u>								25a. REC'D BY REGISTRAR <u>JUN 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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1951-12-15

1951-12-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
EARL		T.		HARCLERODE	JUNE 23, 1968		1:25 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-21-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telegrapher		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PA.		13b. COUNTY Bedford		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER xRix#ix	
14. FATHER'S NAME First Middle Last HAYES HARCLERODE		15. MOTHER'S MAIDEN NAME First Middle Last ANNA SUDER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 705-09-5607		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH week years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 23, 1968, to June 25, 1968, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE DR. G. O. HIMMELWRIGHT				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-25-68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 26, 1968		Hyndman Cemetery		Hyndman, Bedford Co., Pa.			
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.				25a. REC'D BY REGISTRAR DATE JUL - 1 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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EMPL. T. HANCLER ROSE JUNE 23, 1904 1:12

WHITE 1872-1875

U.S.A. ALABAMA

UNIVERSITY OF ALABAMA HOSPITAL

DEPT. OF AGRICULTURE

HAYES HARD BROOK

UNIVERSITY OF ALABAMA HOSPITAL

DEPT. OF AGRICULTURE

UNIVERSITY OF ALABAMA HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH																			
Item #2a, Film 02 7/2/68 km																													
1. DECEASED-NAME (Type or print) ELVA					First P					Middle P					Last HARPER					2a. DATE OF DEATH Month JUNE Day 18 Year 1965 2b. HOUR 5:20 AM									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH 3-6-1904					6. AGE (In years lost birthday) 64 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) W. VA.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWEE					12b. KIND OF BUSINESS OR INDUSTRY Own Home														
13a. USUAL RESIDENCE (Where deceased admission) STATE W. VA.					13b. COUNTY MINERAL					13c. CITY OR TOWN FT. ASHBY					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
14. FATHER'S NAME GEORGE					First GEORGE					Middle WAGONER					Last HANNAH					15. MOTHER'S MAIDEN NAME First HANNAH Middle S Last KETTERMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no					(If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF (c) Anterior perforating ulcer disease															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 15 mos.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION 4-16-68					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of stomach					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1967 , to June 15, 1968 , that (I) (we) last saw the deceased alive on June 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE DR. DONALD B. GROVE															DEGREE MD.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE										22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 6-20-1968					23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery					23d. LOCATION (City or Town) (County) (State) Fort Ashby, W. Va. Mineral														
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.															ADDRESS					25a. REC'D BY REGISTRAR DATE JUN 25 1968					25b. REGISTRAR'S SIGNATURE Charles Judge				

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DEPARTMENT OF THE ARMY

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3-0-1901 WHITE

W.VA. USA

COMBERLAND, MD. MEMORIAL HOSPITAL

W.VA. GENERAL FT. ASHBY

GEORGE WAGONER RANAH KETTERMAN

MEMORIAL HOSPITAL, COMBERLAND, MD.

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DR. DONALD B. GROVE

123 S. CENTRE ST., COMBERLAND, MD.

JUN 6 1962

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
MARTHA		O.		HARRIS		2a. DATE KNOWN OF DEATH		Month Day Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7c. DATE PRONOUNCED DEAD	
FEMALE		WHITE		APRIL 11, 1894		74 YRS.		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH	
MARYLAND		USA		WIDOWED		DIVORCED		ALLEGANY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE		OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		501 CUMBERLAND STREET	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
PATRICK		OFTEN		ANNA		KREITZBURG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		215 34 4570		MRS. MARION SINE		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:								3 Days	
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE									
DUE TO, OR AS A CONSEQUENCE OF									
(b) HYPERTENSIVE CARDIOVASCULAR									
DUE TO, OR AS A CONSEQUENCE OF									
DISEASE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION								20. AUTOPSY?	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JUNE 5, 1968			
				ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5/8/68		HILLCREST BURIAL PARK		CUMBERLAND, MD.			
24. FUNERAL DIRECTOR		BYRON KIGHT		ADDRESS		CUMBERLAND, MD.			
				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				JUN 7 1968					

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WORLD EXHIBITION

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
Item #5, Film G401 6/1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Hattie			Middle Belle			Last Hawse			2a. DATE KNOWN OF DEATH Month Day Year JUNE 9, 1968			2b. HOUR P. 10		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 9, 1968		6. AGE (In years last birthday) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year June 9, 1968			2d. HOUR P. 10		
7a. BIRTHPLACE (State or foreign country) Rio, W. Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 209 Potomac St.			
14. FATHER'S NAME First Middle Last John W. Boone						15. MOTHER'S MAIDEN NAME First Middle Last Lucy Conard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT ADDRESS Mr. Roy C. Hawse, Cumberland, Md.-Son									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>887X</u> Brain Abscesses DUE TO, OR AS A CONSEQUENCE OF Fracture of Nasal Bones Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 11					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>903.0</u>																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year June 1 19 68 3:30 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Lost balance as she arose from chair									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Porch - Home				21f. LOCATION Street or R.F.D. No. City or Town County State 209 Potomac St. Cumberland Allegany Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED June 9, 1968					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county) Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE June 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE JUN 11 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

03814

03813

(M)

(X)

COPIES
1/11/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07814 CERTIFICATE OF DEATH 07818									
1. DECEASED-NAME (Type or print) ANNA				First M	Middle HIETT	Last	2a. DATE OF DEATH Month 8 Day 12 Year 68		2b. HOUR 10:02 AM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12-21-01		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VA.		13b. COUNTY Morgan		13c. CITY OR TOWN PAW PAW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER c/o Postmaster	
14. FATHER'S NAME First JOHN Middle W Last CLINGERMAN		15. MOTHER'S MAIDEN NAME First MARY Middle E Last CHANEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Massive 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 67 to 12 June 19 68 , that (I) (we) last saw the deceased alive on 12 June 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. F. B. Whitworth DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED-DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH				22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/15/1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo		23d. LOCATION (City or Town) (County) (State) Great Cacapon, Morgan W.Va.			
24. FUNERAL DIRECTOR Johnson Funeral Homes, Berkeley Springs, W. Va.				25a. REC'D BY REGISTRAR DATE JUN 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

03618

DEPARTMENT OF STATE

03618

NOV 25 1958

RECEIVED

W

ADMIN

11-21-58

11-21-58

WHITE

FRANCE

ALGERIA

U.S.A.

WEST VIRGINIA

MENTAL HOSPITAL

CUMBERLAND

RAW PAW

WEST VA.

CHANCEY

JOHN

CUMBERLAND

JOHN

CUMBERLAND, MD.

MENTAL HOSPITAL

DR. F. B. WILKINSON

CUMBERLAND, MD.

JUN 1 1959

CERTIFICATE OF DEATH

07815

07819

1. DECEASED-NAME (Type or print) Thomas M. Holmes			2a. DATE OF DEATH Month June Day 26 Year 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/5/1896		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Allegany Street	
14. FATHER'S NAME First Thomas Middle Holmes Last Holmes			15. MOTHER'S MAIDEN NAME First Susan Middle McFarland Last McFarland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. W.W. 1 214-32-3404		17. INFORMANT Mrs. Jeanette Holmes		Address Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441.2 Gastrointestinal hemorrhage, secondary 10 days DUE TO, OR AS A CONSEQUENCE OF (b) Stress ulcers of stomach 10 days DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of abdominal aortic aneurysm PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 451X Aortic aneurysm									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION June 26, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE F.W. Miltenberger		22c. DATE SIGNED June 68		22d. PHYSICIAN'S NAME (Type) F.W. Miltenberger		22e. ADDRESS Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/28/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland A. Md			
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. RECD BY REGISTRAR JUL - 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-10-12

RECORD OF DEATH

12912

June 23, 1902

Holmes

James

5/2/1896

White

Male

Allegany

W. B. A.

Id

Unmarried

Residential (General)

Allegany, Pennsylvania

Interment

Home

Holmes

James

W. B. A. 5-2-1896, James, Pennsylvania, No.

6/23/02 Allegany, West Virginia, A. M.

George, 101 - 1 new, Allegany, W. Va.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Duane Douglas Imler						MATED <input checked="" type="checkbox"/> JUNE 16, 1968			5:30 p M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Dec. 16, 1951	16 YRS.	MONTHS	DAYS	Month Day Year June 16, 1968			5:30 p M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Pennsylvania		USA				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Memorial Hospital-DOA			Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
Penna			Somerset			Hyndman, RD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last Floyd Imler			First Middle Last Ruth Kennell Imler			RD#1, Southampton Tnsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
NO			205-42-1588			Floyd Imler, Hyndman, Pa. RD#1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
9100 Asphyxiation									
Drowning								"	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9298									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)			
			4:30 M. June 16, 1968			Drowned while swimming			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
			Kennell's Mill, Pa			RD#1 Hyndman Somerset Co. Penna.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			June 16, 1968
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			June 19, 1968			Comps Cemetery			Hyndman, RD#1, Somerset Co. Penna.
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, PA.						DATE JUN 21 1968			Charles Judge

01820

00010

FOR FILE
NEW YORK

Trans. Location Index

Date: white 10.10.1950

Barman, John USA

Occupation: Captain - 1st Lt.

Service: American

Rank: Major

10 - 11 - 12 - 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20 - 21 - 22 - 23 - 24 - 25 - 26 - 27 - 28 - 29 - 30 - 31 - 32 - 33 - 34 - 35 - 36 - 37 - 38 - 39 - 40 - 41 - 42 - 43 - 44 - 45 - 46 - 47 - 48 - 49 - 50 - 51 - 52 - 53 - 54 - 55 - 56 - 57 - 58 - 59 - 60 - 61 - 62 - 63 - 64 - 65 - 66 - 67 - 68 - 69 - 70 - 71 - 72 - 73 - 74 - 75 - 76 - 77 - 78 - 79 - 80 - 81 - 82 - 83 - 84 - 85 - 86 - 87 - 88 - 89 - 90 - 91 - 92 - 93 - 94 - 95 - 96 - 97 - 98 - 99 - 100

Address: New York

Occupation

10.10.1950 - 10.10.1950

10.10.1950 - 10.10.1950

10.10.1950 - 10.10.1950

10.10.1950 - 10.10.1950

10.10.1950 - 10.10.1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
BRIDGET			I.		JACKSON	JUNE 2, 1968			10:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		DECEMBER 16, 1883		84 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
FROSTBURG		MINERS HOSPITAL		HOUSEWIFE		OWN HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		FROSTBURG				120 S. GRANT STREET			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOHN					McDONALD	ALICE					HALFPENNY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO			N.A.		FROSTBURG, MD. MR. PAUL JACKSON, 36 WASHINGTON ST.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>4/20</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>H.C.V.D.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>Years.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>443x</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>June 2</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>June 2</u> , 19 <u>68</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John B. Davis</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22c. DATE SIGNED					
JOHN B. DAVIS, M.D.			2 BROADWAY, FROSTBURG, MD. 21532			6/5/68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		6/5/68		ST. MICHAEL'S CEM.		FROSTBURG, ALLEGANY, MD.					
24. FUNERAL DIRECTOR <u>MARILOU M. SOWERS</u>						25a. REC'D BY REGISTRAR <u>JUN 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>			
HOME, 60 W. MAIN, FROSTBURG											

07818

CERTIFICATE OF DEATH

07822

1. DECEASED-NAME (Type or print) DEWEY		First Middle Last W KYLE		2a. DATE OF DEATH Month Day Year JUNE 15 1968		2b. HOUR 5:25 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-27-1898		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) BARTON, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY ALLEGANY		13c. CITY OR TOWN BARTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER ROUTE 1		14. FATHER'S NAME First Middle Last FRANK KYLE		15. MOTHER'S MAIDEN NAME First Middle Last EMMA LEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-01-3751		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>154x</u> (b) <u>Carcinoma of the rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>18 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Anterior circulatory cerebrovascular disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 25, 1967</u> , to <u>June 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>DR. DONALD GROVE</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR. DONALD GROVE				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 6/18/68		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.	
24. FUNERAL DIRECTOR <u>Westernport, Md.</u>				25a. REC'D BY REGISTRAR DATE JUN 19 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10
30M REV. 1-58

07819		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07823		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
CARLTON			H.		LAPP, SR.	JUNE 7, 1968		12:25
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE		WHITE		AUGUST 4, 1891		76 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
FROSTBURG, MD.		U.S.A.				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.		MEMORIAL HOSPITAL		Retired Machinist		Helper-RR		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND				908 OLDTOWN ROAD
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
HENRY			A.		LAPP	MARY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes <input checked="" type="checkbox"/> (If yes give war or dates of service)			War I		705-09-8664			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiac Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4129			DUE TO, OR AS A CONSEQUENCE OF					8 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			(b) Auricular Fibrillation					?
			DUE TO, OR AS A CONSEQUENCE OF					??
			(c) Coronary Arteriosclerosis- Myocardial Fibrosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)								
Osteoporosis - Severe Hypertrophic Arthritis.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1968, to June 7, 1968, that (I) (we) last saw the deceased alive on June 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
DR. S. M. JACOBSON		June 7, 1968			50 PERSHING ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVABLE (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		June 9, 1968		Hillcrest Burial Park		Cumberland, Allegany Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James T. Scarpelli, Cumberland, Md.				JUN 11 1968				

07383

07383



1. The first part of the document is a list of names and addresses, which are mostly illegible due to the quality of the scan. The names appear to be listed in a column, with addresses following them. Some of the names that can be partially discerned include "Mr. J. H. Smith", "Mr. W. B. Jones", and "Mr. C. D. Brown".

2. The second part of the document is a table with several columns. The columns are headed "Name", "Address", "City", "State", and "Zip". The table contains several rows of data, but the text is too faint to read accurately. The data appears to be organized alphabetically by name.

3. The third part of the document is a list of names, possibly a roster or a list of participants. The names are listed in a single column, and some of them are clearly visible, such as "John Doe", "Jane Smith", and "Robert Johnson".

4. The fourth part of the document is a list of names and addresses, similar to the first part. The text is very faint, but the structure is consistent with the first part, with names listed first and addresses following.

5. The fifth part of the document is a list of names, possibly a list of donors or contributors. The names are listed in a single column, and some of them are clearly visible, such as "Mr. A. B. Clark", "Mrs. E. F. Davis", and "Mr. G. H. Evans".

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) DOROTHY JANE LAVIN						2a. DATE KNOWN DF ESTI- DEATH MATED <input checked="" type="checkbox"/> JUNE 21, 1968			2b. HDUR 5:55 P M		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MAY 3, 1948	6. AGE (In years last birthday) 20 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 21, 1968			2d. HOUR 5:55 P M
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK & BAKER			12b. KIND OF BUSINESS OR INDUSTRY DONUT SHOP		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY GARRETT		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 2			
14. FATHER'S NAME First Middle Last ALTON BUTLER				15. MOTHER'S MAIDEN NAME First Middle Last VELMA I. BAKER				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16b. SOCIAL SECURITY NO. 211-38-6575				17. INFORMANT JOSEPH LAVIN, RT. 2, FROSTBURG, MD.				ADDRESS BOX 421-A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED LIVER::; RUPTURED VENA CAVA 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (AUTO ACCIDENT) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 1/2 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164											
19a. DATE OF OPERATION 6-21-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Driver of auto in 2 vehicle collision				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:00 PM 6-21-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of auto in 2 vehicle collision							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 40		21f. LOCATION Street or R.F.D. No. City or Town County State 1 mile west of Frostburg Garrett Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M		22b. DATE SIGNED June 21, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 24, 1968		23c. NAME OF CEMETERY OR CREMATORY JOHNSON CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUN 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				ADDRESS							

0303

0303

DEPARTMENT OF HEALTH

DATE: 11/15/55
TIME: 10:00 AM
PATIENT: J. J. J.
DOCTOR: J. J. J.
NURSE: J. J. J.
PHYSICIAN: J. J. J.
HISTORICAL: J. J. J.
PHYSICAL: J. J. J.
LABORATORY: J. J. J.
X-RAY: J. J. J.
TREATMENT: J. J. J.
PROGNOSIS: J. J. J.
REMARKS: J. J. J.

(WITH ACCOUNT)



RECEIVED
NOV 15 1955
U.S. DEPARTMENT OF HEALTH

RECEIVED
NOV 15 1955
U.S. DEPARTMENT OF HEALTH

0303

0303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-14
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07821										
CERTIFICATE OF DEATH										
07825										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOHN			J. LEGEER			JUNE 16, 1968		11:15P		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE		WHITE		SEPT. 1, 1903		64 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSP.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			GARRETT		GRANTSVILLE					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
JOHN LEGEER			BOWSER ELIZABETH LEGEER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO					HOSPITAL RECORD, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE</u> <u>5150</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY FIBROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SILICOSIS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>15 yr</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5230</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>67</u> , to <u>16 JUNE</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>16 JUNE</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>M. Glick, M.D.</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-18-68</u>		
22d. PHYSICIAN'S NAME (Type) M. GLICK, M.D.				22e. ADDRESS 126 N. SMALLWOOD ST, CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/19/68		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION (City or Town) (County) Grantsville, Garrett, Md.		21502 (State)		
24. FUNERAL DIRECTOR NEWMAN FUNERAL HOME, GRANTSVILLE, MD. <u>Ruth A. Newman</u>				25a. REC'D BY REGISTRAR DATE JUN 21 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

NEWLY RECALLED HOME, GRANVILLE, MD.

M. GLICK, D.D.

126 N. SKILLWOOD ST., CUMBERLAND, MD.

21503

MARYLAND

GRANVILLE

CUMBERLAND, MD.

SACRED HEART HOSP.

MARYLAND

USA

ALLEGY

MALE

WHITE

SETT. 1, 1903

SM

JOHN

1

LEGGER

JUNE

16, 1903

11:12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07822

07826

1. DECEASED-NAME (Type or print) George Herbert Leith			2a. DATE OF DEATH Month June Day 17 Year 68			2b. HOUR P 4:45 M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH 11/4/1914		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) McKeesport Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Celanese worker-retired		12b. KIND OF BUSINESS OR INDUSTRY Lab. Tech.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 207 Grand Ave. Cumb. md.	
14. FATHER'S NAME First George Middle Herbert Last Leith			15. MOTHER'S MAIDEN NAME First Leafy Middle Last Penner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16b. SOCIAL SECURITY NO. 214-07-4761		17. INFORMANT Allegany County Infirmary-Furnace St. ext.		Address P.O. Box 599			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 2250 DUE TO, OR AS A CONSEQUENCE OF (b) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 19.51	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from January 15, 1951 , to June 17, 1968 , that (I) (we) last saw the deceased alive on June 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George M. Simmons				DEGREE 		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/18/68	
22d. PHYSICIAN'S NAME (Type) George M. Simmons				22e. ADDRESS Memorial Hospital, Cumberland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/21/68		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

83830

OFFICE OF DEATH

83830

NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]

DATE OF CREMATION: [illegible] PLACE OF CREMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

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DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First CHARLES		Middle D.		Last LONG		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 21, 1901		6. AGE (In years last birthday) 66 YRS.		7c. DATE PRONOUNCED DEAD Month Day Year June 1, 1968		2d. HOUR 12:45P	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital-DOA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED CONTRACTOR-SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11 WOODLAWN AVENUE			
14. FATHER'S NAME First Middle Last WILLIAM LONG		15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE DICKEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 220-16-6610		17. INFORMANT ADDRESS MRS. MARGARET P. LONG, LA VALE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 410.9 SUDDEN ---											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 1, 1968			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ADDRESS Cumberland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 4, 1968		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL MAUSOLEUM		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE JUN 5 1968	
								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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June 1, 1953

June 1, 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1574
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First HARMON			Middle H.		Last LONG		2a. DATE OF DEATH Month JUNE		Day 1, 1968		2b. HOUR 1:35 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 22, 1892			6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED CITY MAINTENANCE EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 614 FREDERICK ST.						
14. FATHER'S NAME First JACOB			Middle E.		Last LONG		15. MOTHER'S MAIDEN NAME First Annie			Middle M.		Last WAGONER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> (If yes give war or dates of service) NO <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO. 556-10-2040A			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis -</u> <u>185x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Carcinoma - Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>3 Yrs -</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>177x</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/1968</u> , to <u>6/1/1968</u> , that (I) (we) last saw the deceased alive on <u>6/1/1968</u> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Walter N. Himmler M.D.</u>			22c. DATE SIGNED <u>6/3/68</u>			22d. PHYSICIAN'S NAME (Type) DR. W.N. HIMMLER									
22e. ADDRESS 412 N. MECHANIC ST., CUMBERLAND, MD															
23a. BURIAL, CREMATION, REMOVEMENT			23b. DATE 4 JUNE 68			23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MARYLAND ALLEGANY						
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST, CUMBERLAND						25a. REC'D BY REGISTRAR DATE JUN 4 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

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HARBOUR

H.

LONG

JUNE 1, 1960

MALE

WHITE

MARCH 22, 1964

HARBOR

U.S.A.

MEMORIAL HOSPITAL

ALLEGY COUNTY MEMORIAL HOSPITAL

JACOB

LONG

MEMORIAL HOSPITAL

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MEMORIAL HOSPITAL

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07854

DR. W. J. GIBBS

ALLEGY COUNTY MEMORIAL HOSPITAL

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Carl			Middle T.			Last Lowery		
3. SEX Male			4. RACE White		5. DATE OF BIRTH July 11, 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Allegheny		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital (DOA)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) B.O.R.R. Emp.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegheny			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER 204 Valley Street			14. FATHER'S NAME First Thomas			Middle Lowery			Last Savilla		
15. MOTHER'S MAIDEN NAME First LaRue			Middle LaRue			Last LaRue			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		
16b. SOCIAL SECURITY NO. 15-44-11/44			16c. 199-10-1857			17. INFORMANT Audrey Murray			ADDRESS 1140 Salem Ave. Dayton, Ohio		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED JUNE 19, 1968			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE June 21, 68			
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City or Town) (County) (State) Meyersdale Somerset Pa.				24. FUNERAL DIRECTOR Price Funeral Home M. R. Leckemly			
ADDRESS Meyersdale, Pa.				25a. REC'D BY REGISTRAR DATE JUN 24 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
HELEN C. MANLEY						June 16, 1968			7:15 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	12/25/1902	65 YRS.					June 16, 1968	7:15 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.		USA.				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Sacred Heart Hospital			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			Allegany		Ellerslie				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Patrick Burns			Bridget Kenney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			None		Mrs. Donald Brandt, Ellerslie, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4369</u> FULMINATING SEPTICEMIA (STAPHYLOCOCCAL) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) EXTENSIVE DECUBITI DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL VASCULAR ACCIDENT									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS 4 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D., FACP			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			JUNE 16, 1968			
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/19/1968		St. Josephs Cemetery		Midland, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
GEORGE EICHHORN Lonaconing, Md.					DATE JUN 18 1968		<u>Charles Judge</u>		

01810

1782

John 10/10/1960

WILEY

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10111

John 10/10/1960

James White 12/23/1960

11/10/1960

10/10/1960

USA

None

Section Heart Research

Robert and

Alfred

Alfred

10/10/1960

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John 10/10/1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (H)
30M REV. 1-68

07827		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07831					
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year			2b. HOUR MIN.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		22a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4369		C.V.A.		C.V.A.		C.V.A.		C.V.A.		3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1965, to June 9, 1965, that (I) (we) last saw the deceased alive on June 5, 1965, and that (I) (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
B. M. SCHINDLER, M. D.		43 GREENE ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JUNE 12, 1968		ST. PATRICK'S CEMETERY		MT. SAVAGE, MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH R. DURST, FROSTBURG, MD. 21532				DATE JUN 13 1968		Judge					

13331

OFFICE OF DEATH

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G. V. A. 9
L. H. H. H. H. H.

2 off June

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												07832					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First <i>Thomas</i>			Middle <i>Clyde</i>			Last <i>Meister</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>June 19, 1968</i>		2b. HOUR <i>7 P.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 8, 1915</i>		6. AGE (in years last birthday) <i>53</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <i>June 19, 1968</i>		2d. HOUR <i>7 P.M.</i>			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Allegany</i> Md.								
10. CITY OR TOWN OF DEATH <i>Cumberland,</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial, DOA</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Acetone Recovery Opr.</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Cel. Fibres</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Allegany</i>		13c. CITY OR TOWN <i>Cumberland,</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>615 Fairview Ave.</i>							
14. FATHER'S NAME First Middle Last <i>Lawrence L. Meister</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Elsie F. Zembower</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No,</i>			16b. SOCIAL SECURITY NO. <i>214-05-6655</i>			17. INFORMANT ADDRESS <i>Mrs. Bernadette Meister, 615 Fairview Ave. Cumb. Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis, left</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Coronary Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M. D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Rt. # 9 Cumb. Md.</i>				22b. DATE SIGNED <i>June 19, 1968</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>6/22/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Memorial Park</i>				23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany Md.</i>							
24. FUNERAL DIRECTOR <i>H. Wayne George</i> ADDRESS <i>Cumberland, Maryland</i>								25a. REC'D BY REGISTRAR DATE <i>JUN 25 1968</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

10-18-68

Countdown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) MARY			First E. Middle METZ Last			2a. DATE OF DEATH Month 14 Day 1968 Year		2b. HOUR 10:20 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 06-18-91		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 76 DAYS 76 HOURS 76 MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 464 COLUMBIA ST.	
14. FATHER'S NAME First JOHN Middle SWEITZER Last			15. MOTHER'S MAIDEN NAME First AMELIA Middle Lohman Last (NOT KNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-07-6538		17. INFORMANT Address HOSPITAL RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE WDS piggie				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-18-68				
22d. PHYSICIAN'S NAME (Type) DR. W. SPIGGLE				22e. ADDRESS 126 N. SMALLWOOD ST., CUMB., MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/17/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Ph.		23d. LOCATION (City or Town) (County) (State) Cumberland Md				
24. FUNERAL DIRECTOR STEINS FUNERAL HOME				ADDRESS Cumb. Md		25a. REC'D BY REGISTRAR DATE JUN 18 1968		25b. REGISTRAR'S SIGNATURE John J. Judge		

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1952 JUN 14 MON 10:30 AM

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FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or Print)			First HERBERT			Middle FRANKLIN			Last MYERS			2a. DATE KNOWN OF DEATH Month Day Year JUNE 9, 1968			2b. HOUR 4 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/17/18		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 9, 1968 19			2d. HOUR 4 A M	
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Asst. Supervisor				12b. KIND OF BUSINESS OR INDUSTRY Forestry Camp				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Ionaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Boy's Forestry Camp				
14. FATHER'S NAME First Middle Last Jacob Myers			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Huffman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II						16b. SOCIAL SECURITY NO. 214-07-6833		17. INFORMANT Herbert R. Myers, Rawlings, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>303.9</u> ASPHYXIAATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ASPIRATION OF STOMACH CONTENTS DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLISM												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES " ---				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>3222</u>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED								
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				JUNE 9, 1968								
				ADDRESS (Street, city, town, or county) CUMBERLAND, MD.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/11/68		23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>				ADDRESS Charles E. Hafer, 230 Balto. Ave., Cumb., Md.				25a. REC'D BY REGISTRAR DATE JUN 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First RALPH		Middle C.		Last NEAL		2a. DATE OF DEATH JUNE Month 27 Day 1968 Year	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 24, 1884			6. AGE (In years last birthday) 83 YRS.		7b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life) SUPERVISOR CONSTRUCTION			12b. KIND OF BUSINESS OR INDUSTRY PULP & PAPER MILL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 115 FROST AVENUE	
14. FATHER'S NAME First Middle Last ALEXANDER NEAL			15. MOTHER'S MAIDEN NAME First Middle Last MARY A. JACOBS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO				
16b. SOCIAL SECURITY NO. 216-01-8791-A			17. INFORMANT Address 115 FROST AVENUE, MRS. ANNA MAE NEAL, FROSTBURG, MD. 21532							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia - left</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic CVD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u> <u>25 yrs -</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>										
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <input checked="" type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State <input checked="" type="checkbox"/>						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-25, 1968</u> , to <u>6-27, 1968</u> , that (I) (we) last saw the deceased alive on <u>6-27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Martin M. Rothstein</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-28-68</u>		
22d. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.				22e. ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 30, 1968		23c. NAME OF CEMETERY OR CREMATORY FGB. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR JUL - 3 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

28370

28370

RECORD OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		CERTIFICATE NO.		REGISTERED		FILED		INDEXED		SERIALIZED		RECEIVED		DATE		TIME		BY		OFFICE		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012		2013		2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024		2025		2026		2027		2028		2029		2030		2031		2032		2033		2034		2035		2036		2037		2038		2039		2040		2041		2042		2043		2044		2045		2046		2047		2048		2049		2050		2051		2052		2053		2054		2055		2056		2057		2058		2059		2060		2061		2062		2063		2064		2065		2066		2067		2068		2069		2070		2071		2072		2073		2074		2075		2076		2077		2078		2079		2080		2081		2082		2083		2084		2085		2086		2087		2088		2089		2090		2091		2092		2093		2094		2095		2096		2097		2098		2099		2100		2101		2102		2103		2104		2105		2106		2107		2108		2109		2110		2111		2112		2113		2114		2115		2116		2117		2118		2119		2120		2121		2122		2123		2124		2125		2126		2127		2128		2129		2130		2131		2132		2133		2134		2135		2136		2137		2138		2139		2140		2141		2142		2143		2144		2145		2146		2147		2148		2149		2150		2151		2152		2153		2154		2155		2156		2157		2158		2159		2160		2161		2162		2163		2164		2165		2166		2167		2168		2169		2170		2171		2172		2173		2174		2175		2176		2177		2178		2179		2180		2181		2182		2183		2184		2185		2186		2187		2188		2189		2190		2191		2192		2193		2194		2195		2196		2197		2198		2199		2200		2201		2202		2203		2204		2205		2206		2207		2208		2209		2210		2211		2212		2213		2214		2215		2216		2217		2218		2219		2220		2221		2222		2223		2224		2225		2226		2227		2228		2229		2230		2231		2232		2233		2234		2235		2236		2237		2238		2239		2240		2241		2242		2243		2244		2245		2246		2247		2248		2249		2250		2251		2252		2253		2254		2255		2256		2257		2258		2259		2260		2261		2262		2263		2264		2265		2266		2267		2268		2269		2270		2271		2272		2273		2274		2275		2276		2277		2278		2279		2280		2281		2282		2283		2284		2285		2286		2287		2288		2289		2290		2291		2292		2293		2294		2295		2296		2297		2298		2299		2300		2301		2302		2303		2304		2305		2306		2307		2308		2309		2310		2311		2312		2313		2314		2315		2316		2317		2318		2319		2320		2321		2322		2323		2324		2325		2326		2327		2328		2329		2330		2331		2332		2333		2334		2335		2336		2337		2338		2339		2340		2341		2342		2343		2344		2345		2346		2347		2348		2349		2350		2351		2352		2353		2354		2355		2356		2357		2358		2359		2360		2361		2362		2363		2364		2365		2366		2367		2368		2369		2370		2371		2372		2373		2374		2375		2376		2377		2378		2379		2380		2381		2382		2383		2384		2385		2386		2387		2388		2389		2390		2391		2392		2393		2394		2395		2396		2397		2398		2399		2400		2401		2402		2403		2404		2405		2406		2407		2408		2409		2410		2411		2412		2413		2414		2415		2416		2417		2418		2419		2420		2421		2422		2423		2424		2425		2426		2427		2428		2429		2430		2431		2432		2433		2434		2435		2436		2437		2438		2439		2440		2441		2442		2443		2444		2445		2446		2447		2448		2449		2450		2451		2452		2453		2454		2455		2456		2457		2458		2459		2460		2461		2462		2463		2464		2465		2466		2467		2468		2469		2470		2471		2472		2473		2474		2475		2476		2477		2478		2479		2480		2481		2482		2483		2484		2485		2486		2487		2488		2489		2490		2491		2492		2493		2494		2495		2496		2497		2498		2499		2500		2501		2502		2503		2504		2505		2506		2507		2508		2509		2510		2511		2512		2513		2514		2515		2516		2517		2518		2519		2520		2521		2522		2523		2524		2525		2526		2527		2528		2529		2530		2531		2532		2533		2534		2535		2536		2537		2538		2539		2540		2541		2542		2543		2544		2545		2546		2547		2548		2549		2550		2551		2552		2553		2554		2555		2556		2557		2558		2559		2560		2561		2562		2563		2564		2565		2566		2567		2568		2569		2570		2571		2572		2573		2574		2575		2576		2577		2578		2579		2580		2581		2582		2583		2584		2585		2586		2587		2588		2589		2590		2591		2592		2593		2594		2595		2596		2597		2598		2599		2600		2601		2602		2603		2604		2605		2606		2607		2608		2609		2610		2611		2612		2613		2614		2615		2616		2617		2618		2619		2620		2621		2622		2623		2624		2625		2626		2627		2628		2629		2630		2631		2632		2633		2634		2635		2636		2637		2638		2639		2640		2641		2642		2643		2644		2645		2646		2647		2648		2649		2650		2651		2652		2653		2654		2655		2656		2657		2658		2659		2660		2661		2662		2663		2664		2665		2666		2667		2668		2669		2670		2671		2672		2673		2674		2675		2676		2677		2678		2679		2680		2681		2682		2683		2684		2685		2686		2687		2688		2689		2690		2691		2692		2693		2694		2695		2696		2697		2698		2699		2700		2701		2702		2703		2704		2705		2706		2707		2708		2709		2710		2711		2712		2713		2714		2715		2716		2717		2718		2719		2720		2721		2722		2723		2724		2725		2726		2727		2728		2729		2730		2731		2732		2733		2734		2735		2736		2737		2738		2739		2740		2741		2742		2743		2744		2745		2746		2747		2748		2749		2750		2751		2752		2753		2754		2755		2756		2757		2758		2759		2760		2761		2762		2763		2764		2765		2766		2767		2768		2769		2770		2771		2772		2773		2774		2775		2776		2777		2778		2779		2780		2781		2782		2783		2784		2785		2786		2787		2788		2789		2790		2791		2792		2793		2794		2795		2796		2797		2798		2799		2800		2801		2802		2803		2804		2805		2806		2807		2808		2809		2810		2811		2812		2813		2814		2815		2816		2817		2818		2819		2820		2821		2822		2823		2824		2825		2826		2827		2828		2829		2830		2831		28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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07832					07835				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last WALTER, H. NORTHCRAFT					06 Month 05 Day 68 Year			2:35 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		05-14-84		84 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		Retired Employee- Western Md R.R.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				RT.#1, BOX 469, VALLEY RD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last TILMAN PORTER NORTHCRAFT		First Middle Last TATE CATHERINE / NORTHCRAFT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO		705-10-8506		SACRED HEART HOSPITAL-900 SETON DR., CUMB., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Uremia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Chronic Renal Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>general arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Dialysis, Hypertension + ASD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/14</u> , 19 <u>68</u> , to <u>6/5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>DR. J. A. PAGAN</u>								<u>6/5/68</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				<u>5 POTOMAC ST., RIDGELEY, W. VA. 26753</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>6/7/68</u>		<u>Fairview Christian Ch Cemetery</u>		<u>Ingle Smith Bedford Pa</u>			
24. FUNERAL DIRECTOR <u>H. Lee Silcox</u>				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>SILCOX FUNERAL HOME</u>				<u>404 DECATUR ST., CUMB.,</u>		<u>JUN 7 1968</u>		<u>MD</u>	

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U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
NOV 14 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (page 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07833

CERTIFICATE OF DEATH

07836

1. DECEASED-NAME (Type or print) WILLIAM A. O'HAVER			2a. DATE OF DEATH Month JUNE Day 17 Year 1968		2b. HOUR 1:20 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 12, 1898		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN WESTERNPORT	
14. FATHER'S NAME First JOHN Middle W. Last O'HAVER		15. MOTHER'S MAIDEN NAME First STARKEY Middle RACHEL Last O'HAVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 214-03-1731		17. INFORMANT Address HOSPITAL RECORD, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 492X DUE TO, OR AS A CONSEQUENCE OF COR PULMONALE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 2 YEARS 10 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5271					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4 - 20 , 19 68 , to 6 - 11 , 19 68 , that (I) (we) last saw the deceased alive on 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ralph W. Ballin		DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-11-68	
22d. PHYSICIAN'S NAME (Type) RALPH W. BALLIN M.D.		22e. ADDRESS 62 GREENE STREET, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Philos	
23d. LOCATION (City or Town) (County) (State) Westernport Md.					
24. FUNERAL DIRECTOR E. L. Gual		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUN 17 1968	
		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
<div>07834</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>07837</div>																	
1. DECEASED-NAME (Type or Print)			First Charles			Middle William			Last Parks			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 6 Day 21 Year 1968			2b. HOUR 1:30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 17, 1916		6. AGE (In years lost birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month June Day 21 Year 1968			2d. HOUR 1:30 PM		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.								
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Flagman				12b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8 McKay Dr.							
14. FATHER'S NAME First Roscoe				Middle --		Last Parks		15. MOTHER'S MAIDEN NAME First Alexia				Middle --		Last Lake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes,				(If yes give war or dates of service) W. W. # 2		16b. SOCIAL SECURITY NO. 220-10-4630		17. INFORMANT ADDRESS Mrs. Anna R. Parks 8 McKay Dr. Cresaptown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS, ---					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED June 21, 1968									
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Rt. # 9 Cumb. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/24/68		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.									
24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Maryland								25a. REC'D BY REGISTRAR DATE JUN 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
RICHARD			S.		PAULMAN	JUNE 12 1968		8:30A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		WHITE		OCTOBER 4, 1887		80 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
NEW YORK		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			SACRED HEART HOSPITAL			Retired Operator		DRY CLEANING			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BOX 91, CASH VALLEY ROAD		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
CHARLES					PAULMAN	JULIA					PAULMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
NO			214-05-4587			HOSPITAL RECORD, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>3 YEARS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
				5 15 56 6 12 68							
22a. I certify that (I) (this hospital) attended the deceased from <u>5 15 56</u> , 19 <u>68</u> , to <u>6 12 68</u> , that (I) (we) last saw the deceased alive on <u>8 1 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)					
<u>R. W. Ballin, M.D.</u>						22e. ADDRESS					
						62 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JUNE 15, 1968		SUNSET MEMORIAL PARK		CUMBERLAND, MD					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
KIGHT'S FUNERAL HOME CUMBERLAND, MD.		DATE JUN 17 1968				<u>Charles Judge</u>					

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W. B. ELLIOTT, JR.

00712, RM , CHA-1878, JG , T2 547330 3D

RIGHTS: UNRECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 4 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5, Film G401 6/14/68 km

CERTIFICATE OF DEATH

07836

07839

1. DECEASED-NAME (Type or print) First Middle Last RANKIN ALVIN H.			2a. DATE OF DEATH Month Day Year JUNE 5, 1968		2b. HOUR Min 2:30P M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1891 JAN. 22, 1968	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	
12b. KIND OF BUSINESS OR INDUSTRY CELANESE		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	
13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 175 MAPLE STREET	
14. FATHER'S NAME First Middle Last JAMES A. RANKIN			15. MOTHER'S MAIDEN NAME First Middle Last SHATZER FRANCES RANKIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-10-4998		17. INFORMANT BETSY R. RANKIN, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 2 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 RECENT CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-26, 1968 , to 6-5, 1968 , that (I) (we) last saw the deceased alive on 5-19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. W. BALLIN, MD.				22c. DATE SIGNED 6-5-68	
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, MD.				22e. ADDRESS 62 GREEME ST/ CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 8, 1968		23c. NAME OF CEMETERY OR CREMATORY PORTER CEMETERY	
23d. LOCATION (City or Town) (County) (State) ECKHART, MD.					
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.				25a. REC'D BY REGISTRAR DATE JUN 11 1968	
				25b. REGISTRAR'S SIGNATURE Charles Juarez	

(N)

32850

75 201, 22, 2001, WHITE 7104

REC'D

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07837

37840

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		XX Month Day Year		2b. HOUR	
GEORGE		A.		REUSCHLEIN				JUNE 23		68		55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE	WHITE	JUNE 10, 1916		52 YRS.		MONTHS DAYS		HOURS MIN.		JUNE 23, 1968		8:55 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
MARYLAND		USA		WIDOWED		DIVORCED		ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		SACRED HEART HOSPITAL DOA		POWDER OPERATOR		ABL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		ALLEGANY		LaVALE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12 GRANT DRIVE					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
VICTOR		REUSCHLEIN		ROSE		McCORMICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		214 07 2043		MRS. ALICE REUSCHLEIN, LaVALE, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, RIGHT												MINUTES	
410.9 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) CORONARY SCLEROSIS												- - - -	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								22b. DATE SIGNED					
								JUNE 23, 1968					
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				ADDRESS (Street, city, town, or county)					
								CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)							
BURIAL		June 26, 1968		HILLCREST B		URIAL PARK CUMBERLAND MD.							
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
BYRON KIGHT		CUMBERLAND, MD.		JUN 28 1968		Charles Judge							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEMORANDUM FOR THE RECORD

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FOR STATE HEALTH DEPT. I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07838

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07841

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
Okey		Carl	Ritter		June 4, 1968		8 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	June 13, 1891		76 YRS.	June 4, 1968		8:30 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
W. Va.		U. S. A.				Allegany Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland,		212½ S. Smallwood		Shoe repairman		Shoe repair	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Allegany		Cumberland,		212½ S. Smallwood St.	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First Middle Lost
George		C.	Ritter		Elmira		-- Davisson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No.		234-26-0971		Mrs. Nellie C. Ritter		212½ S. Smallwood St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		June 4, 1968	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>Rt. # 9 Cumb. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/6/68		Greenlawn Cemetery		Clarksburg, Harrison, W. Va.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR	
H. Wayne George				Cumberland, Md.		DATE JUN 7 1968	
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07839

MIDDLELAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07842

1. DECEASED-NAME (Type or print) HERMAN			First	Middle	Last	2a. DATE OF DEATH Month JUNE Day 2 Year 1968			2b. HOUR 4:50 P M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 2, 1897			6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) CRESAPTOWN, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Track Foreman			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.			13b. COUNTY Mineral			13c. CITY OR TOWN WILEY FORD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First SOLOMON			Middle ROBISON			15. MOTHER'S MAIDEN NAME First CAREY			Middle EVANS			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 705-07-6314			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1538													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from January 1960 to June 2, 1968 , that (I) (we) last saw the deceased alive on June 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DR. B. SCHINDLER						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 4/1968					
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER						22e. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE June 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery			23d. LOCATION (City or Town) (County) (State) Fort Ashby W. Va					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						ADDRESS		25a. REC'D BY REGISTRAR JUN 7 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

07839

07839

MEMORANDUM FOR THE RECORD
SUBJECT: H. ROBINSON

DATE: AUGUST 2, 1950

TO: MR. ROBINSON

FROM: MR. ROBINSON

SUBJECT: H. ROBINSON

RE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

REFERENCE: H. ROBINSON

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REFERENCE: H. ROBINSON

FOR STATE
HEALTH DEPT.

07848

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07843

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
JOHN				NMI		ROBOSSON			11 a.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	October 9, 1873/94 YRS.						June 6, 1968	6 p.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Little Orleans			Route #1			Farmer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland			Allegany			Little Orleans			Route #1
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
John						Robosson			Caroline Deremer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT
No						216-18-1676			Sarah E. Morgan, Route #1, Little Orleans, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u>Cumberland, Md.</u>			June 6, 1968
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 8, 1968		I.O.O.F. Cemetery		Flintstone, Allegany, Md.			
24. FUNERAL DIRECTOR <u>Charles E. Harer</u> ADDRESS						25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Charles E. Harer, 230 Balto. Ave., Cumb., Md.									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

07842

07844

1. DECEASED-NAME (Type or print) First Middle Last <i>John Joseph Rowan</i>			2a. DATE OF DEATH June Month 19 Day 68 Year		2b. HOUR M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Dec. 8, 1892</i>		6. AGE (In years last birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Allegany</i> Md.	
10. CITY OR TOWN OF DEATH <i>Lavale Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>604 N. Second St.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Elec. Eng.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C.C. of Am.</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Allegany</i>	13c. CITY OR TOWN <i>Lavale Md.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>604 N. Second Street.</i>	
14. FATHER'S NAME First Middle Last <i>J. Thomas Rowan</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Tierney</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or as unknown) (If yes give war or dates of service) <i>Yes WWII</i>		16b. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. John J. Rowan</i> Address <i>604 N. Second St. Lavale Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Previous Myocardial Infarction, Art. C. V. D.</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/2/65</i> , 19____, to <i>6/19/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>6/19/68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>T. F. Lusby M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE/SIGNED <i>6/20/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>T. F. LUSBY M.D.</i>		22e. ADDRESS <i>Box 3366 LAVALE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>6/22/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Restlawn Mem. Pk.</i>	23d. LOCATION (City or Town) (County) (State) <i>Lavale (Allegany) Md.</i>		
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 25 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ELMER		Middle P.		Last SMITH		2a. DATE OF DEATH Month Day Year JUNE 16, 1968		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-12-01			6. AGE (In years last birthday) 66 YRS.		2b. HOUR 7:45A M		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE MARYLAND			3b. COUNTY ALLEGANY		13c. CITY OR TOWN BARTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. #1		
14. FATHER'S NAME First Middle Last CORNELIUS SMITH			15. MOTHER'S MAIDEN NAME First Middle Last JUNE BROADWATER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214016-2461		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 157X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1968, to June 16, 1968, that (I) (we) last saw the deceased alive on June 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. M. Schindler				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/18/68			
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/19/68		23c. NAME OF CEMETERY OR CREMATORY Broadwater			23d. LOCATION (City or Town) (County) (State) Swanton Garrett Md.				
24. FUNERAL DIRECTOR E. L. Boral				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Elizabeth R. TIPTON			2a. DATE OF DEATH Month JUNE Day 27 Year 1968			2b. HOUR 4:10 MIN M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-21-1867		6. AGE (In years last birthday) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and house no.) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND <input checked="" type="checkbox"/> <input type="checkbox"/>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1205 FREDERICK ST.			
14. FATHER'S NAME First ADAM Middle Last BURKETT			15. MOTHER'S MAIDEN NAME First CHRISTINE Middle Last EMERICK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Age — 100 years old Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days:	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) did not attended the deceased from June 22 , 19 68 , to June 27 19 68 , that (I) did not saw the deceased alive on June 27, 1968 , and that in (my own) opinion death occurred on the date and hour and from the causes stated above, (I) did not (did) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE DOCTOR OF MEDICINE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-28-68					
22d. PHYSICIAN'S NAME (Type) DOCTOR P. JAMES		22e. ADDRESS 133 Virginia Ave., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/30/68		23c. NAME OF CEMETERY OR CREMATORY Hellbent Burial Pl. Cumberland Md.		23d. LOCATION (City or Town) (County) (State) Md.					
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		ADDRESS		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515 M
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) MARCUS			First WHITNEY			Middle VOLK			Last		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 05-17-89			2a. DATE OF DEATH Month 3 Day 1968 Year		
7a. BIRTHPLACE (State or foreign country) KANSAS			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GULF OIL CO.			12b. KIND OF BUSINESS OR INDUSTRY GAS STATION		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN LA VALE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First HARRY Middle A. Last VOLK			15. MOTHER'S MAIDEN NAME First ALICE Middle G. Last (SHAFFER)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-05-9472			17. INFORMANT HOSPITAL RECORD				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 volvulus of small intestine											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 31, 1968 , to June 3, 1968 , that (I) (we) last saw the deceased alive on June 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Brings			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6-5-68					
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS			22e. ADDRESS 57 GREENE ST., CUMB., MD., 21502								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/3/68			23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		
24. FUNERAL DIRECTOR KIGHT'S FUNERAL HOME			ADDRESS DECATUR ST., CUMB.			25a. REC'D BY REGISTRAR DATE JUN 10 1968			25b. REGISTRAR'S SIGNATURE Charles J. J...		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 445 (A)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JAMES			ROBERT			WEAKLEY			06 Month 06 Day 68 Year 1:20 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
MALE		WHITE		12-27-42			25 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND		U.S.A.					ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			SACRED HEART HOSPITAL						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		525 WINIFRED ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JAMES			Weakley			Mackenzie, HENRIETTA MacKenzie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			139-10-9522D		HOSPITAL RECORDS, 900 SETON DR., CUMB., MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>congestive heart failure</u>									<u>Two weeks</u>
7469 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>congenital heart lesion (septal defect)</u>									<u>Since birth</u>
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7545									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>1-15-</u> , 19 <u>43</u> , to <u>6-6-</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>6-5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>L. Brings</u>									<u>6-6-68</u>
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS					22e. ADDRESS				
					57 GREENE ST., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		6-8-68		Sunset Memorial Park			Cumberland Allegany Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SILCOX-MERRITT, 404 DECATUR ST., CUMB., MD.					DATE JUN 10 1968		<u>Charles J. J...</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07846

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07849

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MARCELLA		B.		WELLS	JUNE 18, 1968		1:20A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE		WHITE		JULY 17, 1894		73 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		USA				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.		SACRED HEART HOSP.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		FROSTBURG				10 FROST AVENUE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
DARBY		BRADY		SCALLEY MARCELLA SCALLEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name or unknown (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		N.A.		213-22-3257 HOSPITAL RECORD, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) CA OF CERVIC (PAPILLARY)								8 YEARS
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION								
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19								
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)								
21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 10 - 6, 1967, to 6 - 10, 1968, that (I) (we) last saw the deceased alive on 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE R. W. Ballin								22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.								
22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		JUNE 20, 1968		ST. MICHAEL'S CEM.		FROSTBURG, MARYLAND		
24. FUNERAL DIRECTOR M. SOWERS, 60 W. MAREN ST. HAVER-SOWERS FUNERAL HOME, FROSTBURG, MD.								
25a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE
JUN 24 1968								Charles Judge

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STATE OF TEXAS

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IN SENATE, FEBRUARY 1, 1880.

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

FOR THE YEAR 1879.

BY THE COMMISSIONERS OF THE LAND OFFICE.

AND BY THE COMMISSIONERS OF THE LAND OFFICE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-14
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07847 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First WALTER		Middle		Last WINEBRENNER		2a. DATE OF DEATH Month 4 Day 1968 Year		2b. HOUR 4 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 23, 1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY LUMBER COMPANY					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 2, BOX 311			
14. FATHER'S NAME First JOHN		Middle WINEBRENNER		Last MARY		15. MOTHER'S MAIDEN NAME First BEAL		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-10-9877-A		17. INFORMANT Address EMANUEL WINEBRENNER, FROSTBURG, MD. RT. 2, BOX 311					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>CVD</u> (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs - years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1968</u> to <u>June 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John B. Davis</u>		DEGREE JOHN B. DAVIS, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/5/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 6, 1968		23c. NAME OF CEMETERY OR CREMATORY PORTER CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, MD.					
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

07848		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07851			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First PAUL		Middle E		Last WRIGHT		Month 6 Day 14 Year 68		2:40P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-2-23		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY R.R. SHOPS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 29 BEALL ST.	
14. FATHER'S NAME First THOMAS		Middle Last WRIGHT		15. MOTHER'S MAIDEN NAME First IRENE		Middle Last PAPE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		(If yes give war or dates of service) W.W. 2		16b. SOCIAL SECURITY NO. 218-12-5091		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portal Thrombosis</u> 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810 <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8 June 1968</u> , to <u>14 June 1968</u> , that (I) (we) last saw the deceased alive on <u>14 June 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James G. Stegmaier</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>16 June 68</u>			
22d. PHYSICIAN'S NAME (Type) DR. JAMES G. STEGMAIER				22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-17-68		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, ALLEGANY, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JUN 20 1968		25b. REGISTRAR'S SIGNATURE <u>R. Charles Judge</u>	

